NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 221 W DIVISION ST	
OAK GROVE CHRISTIAN RETIREMENT VILLAGE DEMOTTE, IN46310	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CO CO CO CO CO CO CO CO CO C	(X5) COMPLETION DATE
FO000 This visit was for a Recertification and State Licensure Survey. Survey dates: June 1, 2, 3 and 7, 2011 Facility number: 010823 Provider number: 155667 AIM number: 200236630 Survey team:: Marcia Mital, RN, TC Regina Sanders, RN Census bed type: SNF: 14 SNF/NF: 34 Total: 48 Census Payor type: Medicare: 10 Medicaid: 28 Other: 10 Total: 48 Sample: 12 Supplemental Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 LAC 16.2. Quality review completed 6/9/11	DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

47SV11

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL	
		155667	B. WING			06/07/2	011
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE		221 W E	DDRESS, CITY, STATE, ZIP CODE DIVISION ST TE, IN46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Τ'	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	Cathy Emswiller RN						
F0225 SS=D	have been found gor mistreating residhave had a finding nurse aide registry mistreatment of reof their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including in and misappropriating reported immediate the facility and to with State law through (including to the Stagency). The facility must halleged violations and must prevent the investigation is the reported to the adding representative and accordance with State survey and covering days of the	nvestigations must be ministrator or his designated I to other officials in tate law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective					
	Based on record	review and interview, the choroughly investigate	F02	225	Submission of this plan of correction and credible allegation of compliance does not constitute.		07/07/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155667	B. WIN			06/07/2	011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	8		1	DIVISION ST		
OAK GR	OVE CHRISTIAN F	RETIREMENT VILLAGE		1	TTE, IN46310		
							975)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
IAG	and report to the Indiana State Department		+	IAG	an admission of the certified	and	DAIL
	1 -	-			licensed provider, Oak Grove		
	of Health in a tir	-			Christian Retirement Village		
	allegation of abu				the allegations contained in t		
		gh treatment by CNA #2			survey report are a true and		
	for 1 of 12 resident	ents reviewed for abuse in			accurate portrayal of the pro		
	a sample of 12.	(Resident #37)			of nursing care of services a		
					health care facility. Oak Gro Christian Retirement Village		
	Findings include	»:			licensed and certified provide		
					recognizes its obligation to	- ,	
	A facility policy	, titled, "Abuse/Unusual			provide legally and medically	/	
					required care and services to		
	Occurrences", dated 09/24/09, received from the Administrator as current,				residents in an economic and	d	
		· · · · · · · · · · · · · · · · · · ·			efficient fashon.F2251. No	4	
	1	the event the resident or			residents were adversely afformation by the alleged deficiency. The state of the st		
		al makes an allegation,			allegation of abuse for reside		
		se shall initiateB. Report			#37 was reported to ISDH o		
	immediately to t	he Administrator and the			9/14/10. The allegation was		
	Director of Nurs	ing5. The			thoroughly investigated at th	е	
	Administrator/D	esignee shall be			time of the allegation via	7	
	responsible for i	nitiating the			conversation with resident #3 The investigation was compl		
	investigations	All reportable unusual			and reported to the ISDH wit		
		luding reports of			days of the initial report.2. A		
		own abuse shall be			residents have the potential	to be	
	_	24 hours to the Indiana			affected by the alleged defici		
	1 *	at of health (sic)"			practice. DON/Designee wil		
	State Departmen	at or nearth (sie)			review the 24 hour report she for the past 6 months to iden		
	Davious of a faci	lity "Eay/Incident			any potential areas that warr	•	
		lity,"Fax/Incident			further investigation.3. The		
	Report", Dated (Abuse/Unusual Occurrence		
	1 ^	he initial report with the			Policy was reviewed. All sta		
	1 -	up report was sent to the			be inserviced on the policy w	/ith	
	Indiana State Department of Health				emphasis on reporting	will	
(ISDH) and Adult Protective Services				obligations. DON/Designee interview 5 residents weekly			
	(APS). The report indicated, "Res				identify any issues that warra		
	(resident) (reside	ent #37) voiced concerns			further investigation X 30 day		
	1 ' ' '	renders care to him. He			then 5 monthly X 60 days.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155667		LDING	00	06/07/2	
		133007	B. WIN		PRESIDENCE CONTROL CON	00/01/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE DIVISION ST		
OAK GR	OVE CHRISTIAN F	RETIREMENT VILLAGE		1	TTE, IN46310		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	- 04	DATE
	1	is rough c/ (with) him &			DON/Designee will review th hour report sheets at least 5	le 24	
	1	d that CNA causes him			times weekly to identify areas	s of	
	1 -	nders care" The report			concern that may warrant fur		
	1	reported to the Director of			investigation. This audit will		
	1	3/10. The investigation			ongoing. DON was given 1: reinstruction by the Administi		
		which was received form			regarding reporting/investiga		
	1	Sursing (DoN) on 6/2/11			responsibilities/obligations.4.	~	
	1	dicated the allegation was			DON/Designee will summarize	ze	
	1 -	dent's daughter on			the results of the audits and	4	
	09/09/10.				present the data to the Quali Assurance committee month		
					identify any trends/patterns t	, ,	
	1	n of the allegation,			warrant further corrective		
	received from th	e Director of Nursing			actions. The audits will conti		
	indicated:				aftger the initial time frame u the QA committee feels that		
					least a 95% compliance three		
	"On Friday, Sep	t. 10, 2010 it was reported		has been met.5. Date of			
	to me that reside	ent (resident name)			compliance: July 7, 2011		
	(resident #37) d	aughter had reported to					
	nurse (Nurse's n	ame) (LPN #1) that					
	(resident name)	had concerns regarding					
	the care that he	was receiving from (CNA					
	name) (CNA #2)). She said that (CNA					
	name) was rough	n with (resident name)					
	and that (residen	t name) did not like the					
	way that (CNA r	name) handled himI told					
	(resident name)	that I had heard that he					
	had some concer	rns with the way (CNA					
	name) treats him	. He nodded his head yes.					
	I asked him to ex	xplain to me what the					
	concerns were. I	He said that he feels like					
	(CNA name) is a	big guy and that he does					
	things quickly as	nd abruptly at times.' He					
	said that he som	etimes stretches his legs					
	out when he put	s his pants on and that his					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE S COMPL	
		155667	A. BUI			06/07/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	DIVISION ST		
OAK GR	OVE CHRISTIAN RI	ETIREMENT VILLAGE		1	TE, IN46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		,		TAG	DEFICIENC!)		DATE
	~	nes afterwards. I asked					
		t that (CNA name) was					
	~	himhe said 'no'. I					
		(CNA name) and was					
		left him a note with					
	be a little more ca	concerns and told him to					
		(resident name)"					
	rendering care to	(resident name)					
	" Monday Sont	ember 13, 2010. (LPN					
	* *	called at about 7 p.m.					
	l '` ' '	ident name) daughter					
	`	nat (resident name) had					
	1 ^	NA name) was 'mean' to					
		dered care. I told (LPN					
		the daughter that I had					
	l '	ent name) and that I felt					
	^ `	s resolved(CNA name)					
		ker) 09/15/10 3:30					
		as aware of it and was					
	1 *	sident name) daughter					
	^	e's name) on Thursday,					
	`	10(resident name)					
	1 * 1	ercan be rough at					
	times"	1can oc rough at					
	tillies						
	 "Tuesday Sent	ember 14, 2010Soc					
	• • •	Director to talk with					
	l ` ′	.He told her that he does					
	· ′	with the way (CNA name)					
	_	im. That he is rough and					
		(Social Service Director					
		ion with (resident name),					
	· · · · · · · · · · · · · · · · · · ·	ner investigate and put					
	1 decided to fulfill	ioi investigate and put					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 47SV11

Facility ID:

010823

If continuation sheet

Page 5 of 22

DENTIFICATION NUMBER: 155667 A BUILDING Q	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE OX1D SUMMARY STATEMENT OF DEFICIENCIES (ICACI ID PRICINCY MIST BE PRICEDED BY TULL) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (ICNA name) on suspension pending outcome of investigation" This was five days after the allegation was first voiced by the Resident's daughter on 09/09/10. She indicated the ISDH had not been notified because she did not feel it was an issue after she talked to the resident on 09/10/10. She indicated the Resident's daughter had eported the rough treatment to her on 09/09/10. She indicated the Resident's daughter had eported the rough treatment to her on 09/09/10. She indicated she left a note for the DoN and wasn't sure if she should have called someone. During an interview on 06/02/11 at 4 p.m., the Administrator indicated he now understood the allegation should have been reported immediately. Resident #37's record was reviewed on 06/02/11 at 11:40 a.m. The resident's	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	I DING	00	COMPL	ETED
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understood the allegation should have been reported immediately. Resident #37's record was reviewed on 06/02/11 at 11:40 a.m. The resident's		-						
been reported immediately. Resident #37's record was reviewed on 06/02/11 at 11:40 a.m. The resident's		•						
Resident #37's record was reviewed on 06/02/11 at 11:40 a.m. The resident's			_					
06/02/11 at 11:40 a.m. The resident's		been reported im	imediately.					
06/02/11 at 11:40 a.m. The resident's		D: 1 #27!						
diagnosis, included, but was not limited								
		diagnosis, includ	led, but was not limited					
to, dementia.		to, dementia.						
A quarterly/14 day Minimum Data Set		A quarterly/14 d	ay Minimum Data Set					
(MDS) assessment, dated 07/14/10,			_					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING		NSTRUCTION 00	COM	TE SURVEY MPLETED 7/2011			
	PROVIDER OR SUPPLIER	I ETIREMENT VILLAGE	B. WIIN	STREET A	DDRESS, CITY, STATE, ZIP CODE DIVISION ST TE, IN46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	indicated the resi	dent had short term					
	04/20/10, indicat	s Examination", dated ed a score of 4 incorrect of 3-5 errors indicated impairment).					
	at 1 p.m., indicat a staff member. It several occasions fast and too roug pulls them out caback, groin). That he cried from 11 r/t (related to) disdidn't want to car any harm becaus me when no one During an intervirus. Resident #3 sometimes is a cometimes is a cometimes.	ces Notes, dated 09/14/10 ed, "res. concerns about Res alertHe stated on sstaff member is too hstaff member just using pain all over (legs, it particular night he said p (p.m.) until 6 a (a.m.) scomfort and painhe use him (staff member) e I don't want him to hurt is around" sew on 06/02/11 at 11:30 of stated, "Staff handling oncern" He indicated it since he has been treated					
	3.1-28(d)						

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155667	B. WIN			06/07/2	011
			D		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			221 W I	DIVISION ST		
	OVE CHRISTIAN R	ETIREMENT VILLAGE	_	DEMOT	ГТЕ, IN46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
F0226 SS=D	written policies and mistreatment, negland misappropriate. Based on record facility failed to the policy for investical allegations of about Administrator, and Department of Hallegation of rought facility also facility's policy for resident related to work at the facility rough treatment of the residents reviewed of 12. (Resident facility policy, Occurrences", date from the Administrated, "In the another individual the licensed nurse immediately to the Director of Nurse be initiated by a facility policy.	and to the Indiana State ealth related to an gh treatment by CNA #2. failed to follow the for protection of the for a CNA continued to ty after an allegation of was reported for 1 of 12 and for abuse in a sample #37 and CNA #2) titled, "Abuse/Unusual ted 09/24/09, received strator as current, the event the resident or al makes an allegation, the shall initiateB. Report the Administrator and the ing2interventions will dicensed nurse to protect further abuse5. The	F0	226	F226:1. No residents were adversly affected by the alleg deficiency. The allegation of abuse for resident #37 was reported to the ISDH on 9/14 The allegation was thoroughl investigated at the time of the allegation via conversation were sident #37. The investigation was completed and reported the ISDH within 5 days of the initial report. The Administration was notified of the initial allegation on 9/10/10.2. All residents have the potential that affected by the alleged deficiency.3. The abuse/Unto Occurrence policy was review All staff will be inserviced on policy with emphasis on repositions. Administrator with review all allegations of abuse ensure that proper/timely notification and reporting was completed.4. The DON/Desi will summarize results of the audits and present data to the Quality Assurance Committee monthly to identify additional trends/patterns warranting fure corrective actions. The audit continue past the initial time frame until the QA Committee feels that at least a 95% compliance threshold has be met.5. Date of Compliance:	/10. y e eith on to e tor so be usual wed. the orting II e to e e e e e e e e e e e e e e e e e e e	07/07/2011

010823

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155667		(X2) M A. BUI B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/07/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					DIVISION ST		
OAK GR	OVE CHRISTIAN F	RETIREMENT VILLAGE		DEMOT	ΓΤΕ, IN46310		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	responsible for i	· · · · · · · · · · · · · · · · · · ·		1/10	7, 2011		DITTE
	1 ^	ncluding removing the			,		
	1	om the facilityin order to					
	1	nt is protected from any					
	1	busive acts while the					
	incident is being	investigated. Measures					
	shall include,, bu						
	tosuspension of	of staff member allegedly					
	involvedAll re	portable unusual					
	occurrences, inc	luding reports of					
	suspected or kno	own abuse shall be					
	reported within 2	24 hours to the Indiana					
	State Departmen	at of health (sic)The					
	1	c) shall immediately					
	1 '	estigate all reportable					
	1	luding but not limited to					
	1	pected resident abuse,					
	1 -	mentwhether by staff or					
	others"						
	Review of a faci	lity,"Fax/Incident					
	1	09/14/10 at 1:35 p.m.,					
	1 -	tial report with the five					
	1	port was sent to the					
	1 ' '	partment of Health					
	1	It Protective Services					
	(APS). The rep	ort indicated, "Res					
	(resident) (reside	ent #37) voiced concerns					
	about how CNA	(CNA #2) renders care to					
	him. He stated t	hat CNA is rough c/					
	(with) him & 'to	o fast'. He said that CNA					
	1	when he renders care"					
	_	ated it was reported to the					
	Director of Nurs	ing on 09/13/10. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 47SV11 Facility ID: 010823

If continuation sheet

Page 9 of 22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155667	A. BUI			06/07/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	DIVISION ST		
OAK GR	OVE CHRISTIAN R	ETIREMENT VILLAGE		1	TTE, IN46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG	investigation of the allegation which was			IAG	DEFICIENCE (DATE
		e Director of Nursing					
		at 10:30 a.m., indicated					
	` ′	s made by the resident's					
	daughter on 09/0	-					
		· · - · ·					
	The investigation	of the allegation,					
	~	e Director of Nursing					
	(DoN) indicated:	•					
	"On Friday, Sept	. 10, 2010 it was reported					
	to me that resider	nt (resident name)					
	(resident #37) da	ughter had reported to					
	nurse (Nurse's na	me) (LPN #1) that					
	(resident name) h	nad concerns regarding					
	the care that he w	vas receiving from (CNA					
	l '` ' '	. She said that (CNA					
	, ,	with (resident name)					
	`	t name) did not like the					
	` `	ame) handled himI told					
	·	hat I had heard that he					
		ns with the way (CNA					
	· · · · · · · · · · · · · · · · · · ·	. He nodded his head yes.					
		plain to me what the					
		le said that he feels like					
	'	'big guy and that he does					
		id abruptly at times.' He					
		times stretches his legs					
	_	his pants on and that his nes afterwards. I asked					
	-	t that (CNA name) was					
	ı	himhe said 'no'. I					
	· ·	(CNA name) and was					
	_	left him a note with					
	unsuccessiui 30 I	ion min a note with					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 47SV11

Facility ID:

010823

If continuation sheet

Page 10 of 22

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	A. BUI	A. BUILDING D. WING		CON	TE SURVEY MPLETED 7/2011
PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE DIVISION ST TE, IN46310		
SUMMARY S (EACH DEFICIEN REGULATORY OR (resident name) of be a little more or rendering care to "Monday, Sept name) (LPN #5) and said that (resident name) to assure the reported that (CN him when he reniname) to assure the spoken to (resident like the issue was (midnight coword p.msaid she with present when (restalked with (nursident September 9, 200 complained to he times" "Tuesday, Sept (Social) Service (resident name) have a problem with renders care to he service of the summary of the summ	ETIREMENT VILLAGE TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) concerns and told him to areful when he is (resident name)" ember 13, 2010. (LPN called at about 7 p.m. ident name) daughter nat (resident name) had JA name) was 'mean' to dered care. I told (LPN he daughter that I had not name) and that I felt is resolved(CNA name) ker) 09/15/10 3:30 as aware of it and was sident name) daughter e's name) on Thursday, 10(resident name) ercan be rough at ember 14, 2010Soc Director to talk with .He told her that he does with the way (CNA name) im. That he is rough and	B. WIN	G STREET A 221 W [DIVISION ST	TION D BE	(X5) COMPLETION DATE
name) conversation I decided to furth (CNA name) on soutcome of investigations after the allowards.	(Social Service Director on with (resident name), her investigate and put suspension pending stigation" This was five egation was first voiced daughter on 09/09/10.					

		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155667	B. WIN			06/07/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	-
	OVE CUDICTIAN D	ETIDEMENT VIII I ACE		1	DIVISION ST	
		ETIREMENT VILLAGE			ΓΤΕ, IN46310	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
mo	A time detail form, dated 09/01/10			mo	·	DATE
), indicated CNA #2				
	~	k in the facility on				
		·				
		n 09/13/10 on the night				
	shift.					
	During on interni	iew on 06/02/11 at 11				
	~	dicated she had found out				
	l '	ion on 09/10/10. She				
		OH had not been notified				
		not feel it was an issue				
	after she talked to					
		dicated CNA #2 was				
	suspended on 09/	/14/10.				
	During an intervi	iew on 06/02/11 at 11:20				
	~	licated the resident had				
		was rough with him				
		indicted the Resident's				
		orted the rough treatment				
		0. She indicated she left				
		N and wasn't sure if she				
	should have calle					
	Should have calle	A SUMEUM.				
	 During an intervi	iew on 06/02/11 at 4				
	~	strator indicated he now				
	1 *	llegation should have				
	been reported im	_				
	Jeen reported IIII	inicalatory.				
	Resident #37's re	ecord was reviewed on				
		a.m. The resident's				
		ed, but was not limited				
	to, dementia.	out has not million				
	,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	e survey Pleted 7/2011			
	NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 221 W DIVISION ST DEMOTTE, IN46310					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	(MDS) assessme	ay Minimum Data Set nt, dated 07/14/10, dent had short term as.							
	04/20/10, indicat	s Examination", dated ed a score of 4 incorrect of 3-5 errors indicated impairment).							
	at 1 p.m., indicat a staff member. I several occasions fast and too roug pulls them out ca back, groin). That he cried from 11 r/t (related to) did didn't want to cat any harm becaus me when no one	ces Notes, dated 09/14/10 ed, "res. concerns about Res alertHe stated on sstaff member is too hstaff member just rusing pain all over (legs, at particular night he said p (p.m.) until 6 a (a.m.) scomfort and painhe ruse him (staff member) e I don't want him to hurt is around"							
	a.m., Resident #3	37 stated, "Staff handling oncern" He indicated it since he has been treated							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
		155667	A. BUILDING			— 06/07/2011	
		100007	B. WIN		ADDRESS SITU STATE SID CODE	00/01/2	
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
OAK GROVE CHRISTIAN RETIREMENT VILLAGE				1	DIVISION ST FTE, IN46310		
			DEMOTI				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0281 SS=D		ded or arranged by the professional standards of					
	Based on record of facility failed to estandards were for a MAR (Medicat Record) prior to a medication for 1 12. (Resident #1 Findings Include 1 Resident #1's r 6/2/11 at 2:45 p.r diagnoses include to, congestive her hypertension. A physician order, of "proventil (respirato QID (four times a data A MAR, dated 6/11, nebulizer treatment value). The MAR indicated been initialed as admitted when reviewed on 6.	resident in a sample of and LPN #3) : record was reviewed on m. Resident #1's ed but were not limited art failure, asthma, and. dated 5/31/11, indicated ry medication)via nebulizer my)" indicated the proventil was to be administered at 8 and 8 p.m. the nebulizer treatment had ministered on 6/2/11 at 4 p.m.	FC	0281	F281:1. No residents were adversely affected by the alledeficiency. Resident #1 receprescribed medication within scheduled administration parameters.2. All residents the potential to be affected by alleged deficiency.3. LPN # counseled for not following professional standards of professional standards o	have by the 3 was actice n. blicy policy nee 5 x 2 X urses therding ct to ed ze udits lity hly to erns	07/07/2011

010823

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
and Plan of Correction identification number: 155667		A. BUILDING B. WING		06/07/2011				
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
			221 W DIVISION ST					
		ETIREMENT VILLAGE	DEMO	OTTE, IN46310				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE			
	treatment yet. She i	but had not administered the ndicated she was just getting sident her breathing treatment.		actions. The audits will cont past the initial time frame un QA Committee feels that at le	til the			
		d to get the medication out of		a 95% compliance threshold been met.5. Date of Compliance: July 7, 2011				
	The "Geriatric Medi	cation Handbook", Eighth		Compliance: July 1, 2011				
	Edition, pages 170-1	72, indicated "Steps of						
		strationTwo methods are medications, and each facility						
	_	these methodsThe most						
	common method is t							
		R medication administrationA lled 'charting by exception.' In						
	this method, the nur	rse initials the MAR as each						
	medication is opene medication cup"	d and placed into the						
	3.1-35(g)(1)							
F0282 SS=D	facility must be pro	ded or arranged by the ovided by qualified persons n each resident's written						
		review and interview, the	F0282	F282:1. Resident #1 had lab	os 07/07/2011			
		ensure physician's orders		completed on 6/6/11 per physician order. MD is awar	e that			
		lated to laboratory tests		labs (BMP and PT/INR) were	l l			
	for 1 of 12 reside laboratory tests in			completed on 6/2/11. A clarification order was received	ed to			
	(Resident #1)	n a sampie or 12.		do the labs on 6/6/11 and the	en			
	(=100100110 11 1)			again clarified to do the PT/II on 6/3/11.2. All residents that				
	Findings include	:		have physician orders for lab				
				have the potential to be affect	l l			
	Resident #1's rec	ord was reviewed on		by the alleged deficient practi Physician orders will be audi				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155667 06/07/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 221 W DIVISION ST OAK GROVE CHRISTIAN RETIREMENT VILLAGE DEMOTTE, IN46310 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 6/2/11 at 2:45 p.m. Resident #1's on all residents for the last 3 months to asure that physician diagnoses included but were not limited orders wer followed regarding to, congestive heart failure, atrial labs. MD will be notified of any fibrillation, and. hypertension. labs that were not completed per order.3. DON/Designee will audit Physician orders to identify those A physician's order, dated 5/31/11, orders which contain orders for indicated "...PT/INR (test for blood labs to be completed. This audit clotting time) & BMP (basic metabolic will include labs completed to profile) on 6-2-11 then weekly on ensure that labs are completed per physician order. This will be Monday..." done daily (Monday - Friday with Monday's audit to include There was a lack of documentation in the weekend) X 30 days and then resident's record to indicate the laboratory weelkly X 60 days and then monthly. All Nurses will be tests had been completed as ordered by inserviced regarding following the physician. physician orders for labs.4. The DON/ Designee will summarize results of audits and present the During an interview on 6/2/11 at 3:35 data to the Quality Assurance p.m., LPN #3 indicated the laboratory Committee monthly for review to tests had not been drawn today. She identify additional trends/patterns indicated they had to draw the blood for warranting further corrective the laboratory tests and the laboratory action. Audits will continue until the QA Committee determine that would come and pick it up. She indicated a 95% compliance threshold is she wanted to be able to draw the blood met.5. Date of Compliance: July for both laboratory tests at the same time 7, 2011 was why she hadn't done the laboratory tests today. She indicated she had wanted to find out which physician to send the results of the laboratory tests to. The MAR (Medication Administration Record), dated 6/11, indicated "BMP call (physician name) c (with) results...PT/INR call (physician name) c results..."

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

47SV11

Facility ID: 010823

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		DING	00	COMPLETED	
		155667	B. WING	3		06/07/2	011
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 221 W DIVISION ST DEMOTTE, IN46310				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0328 SS=D	3.1-35(g)(2) The facility must e proper treatment a special services: Injections; Parenteral and ent Colostomy, ureter Tracheostomy care; Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on observatinterview, the fact PICC (Peripheral Catheter) was assistant and prostness.	nsure that residents receive and care for the following teral fluids; ostomy, or ileostomy care; e;	F0.	TAG 328	F328:1. Resident #49 was discharged on May 19, 2011. Resident #1- Oxygen liter flowas corrected immediately. Residents oxygen order was revised to allow for titration o	w f	07/07/2011
	PICC line and fa was administered physician for 1 o in a total sample (Residents #1 and Findings include 1. Resident #1's r 6/2/11 at 2:45 p.r diagnoses include	iled to ensure oxygen I as ordered by the If 3 residents with oxygen of 12 residents. Id #49) It is a second was reviewed on			revised to allow for titration of oxygen for shortness of breath or to keep oxygen saturation levels >90%.2. Any resident with an order to remove a PICC line has the potential to be affected. All residents that have physician orders for oxygen administration have the potential to be affected by alleged deficiency. All residents records with oxygen orders were reviewed and plans of care were updated to match orders.3. All nursing staff will be inserviced on the policy for Oxygen Administration with emphasis on importance of administering correct liter flow. DON/Designee will prepare a		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155667 06/07/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 221 W DIVISION ST OAK GROVE CHRISTIAN RETIREMENT VILLAGE DEMOTTE, IN46310 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The admission physician's orders, dated master list of residents utilizing oxygen therapy and their 5/31/11, indicated oxygen at 2 liters via physician order for liter flow. List (by way of) nasal canula. will be updated as needed.Each oxygen administration device (concentrator, liquid tank and/or Resident #1 was observed during the protable tank) will be labeled with initial tour on 6/1/11 at 9:25 a.m., with a sticker that will reflect the LPN #3 present, with her oxygen on 3.5 correct lilter flow. Unit secretary liters. During interview at that time, LPN will audit stickers on a weekly #3 indicated the resident's oxygen was basis to ensure that the liter flow is correct. DON/Designee will suppose to be on 3 liters. LPN #3 then make rounds twice daily to changed the oxygen to 3 liters. ensure that residents are on the correct liter flow of oxygen. Any Resident #1 was observed on 6/2/11 at areas of noncompliance will be immediately rectified. Staff 8:15 a.m., with her oxygen on 2.5 liters. members will be subject to 1:1 reinstruction and further LPN #3 was observed checking the disciplinary action as appropriate. Twice daily rounds will be resident's oxygen on 6/2/11 at 8:16 a.m.. completed X 30 days, then LPN #3 indicated the resident's oxygen weekly X 60 days and randomly was on 2.5 liters. LPN #3 then changed thereafter.All nurses will be the resident's oxygen to 2 liters. inserviced on the policy for removal of a PICC line. DON/Designee will audit any record of a resident who has had removal of a PICC line to ensure proper documentation. Any nurse found to be noncompliant with documentation expectations will be subject to 1:1 reinstruction and further disciplinary action as appropriate. 4. DON/Designee will summarize results of audits and will present data to the **Quality Assurance Commettee** monthly to identify further trend/patterns that warrant further corrective action. The audits will continue past the original time

010823

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155667		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 06/07/2	LETED	
	PROVIDER OR SUPPLIEF	ETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST TTE, IN46310	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	diagnoses includ to, stroke and an A physician's ord indicated an orderesident's PICC I A Nurses' Note, indicated, "PIC The Nurses' Note of an assessment integrity, and lend the During an interval.m., the Directo indicated the PIC measured when in Central Venous Removal of a PIC from the DoN or indicated, "AssiteInspect the and length. Docu	der, dated 05/05/11 er to discontinue the ine. dated 05/05/11 at 9 p.m., CC line discontinued" es lacked documentation of the catheter site, tip agth. iew on 06/03/11 at 10 r of Nursing (DoN) CC line should have been it was discontinued. lity policy, titled, Catheter Procedures CC Line", received in 06/03/11 at 10:15 a.m., sess the catheter exit catheter tip and integrity		frame unitl the QA com determines that a 95% compliance threshold is Date of Compliance: Ju	s met.5.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155667	B. WING 06/07/2011				
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				DIVISION ST		
OAK GR	OVE CHRISTIAN R	ETIREMENT VILLAGE			TTE, IN46310		
					, III - III		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	3.1-47(a)(2)						
	3.1-47(a)(6)						
F0367		must be prescribed by the					
SS=D	attending physicia	п.		a	F070:4 Decident #0:#-	_	0-10-10-11
			FU	367	F376:1. Resident #8: cottag cheese was obtained and se		07/07/2011
		ation, record review, and			to resident.Resident #24 and		
	interview, the fac	cility failed to provide			resident #31: large meat por		
	therapeutic diets as ordered by the resident's physician, related to large meat				were obtained and served to		
					residents.2. All residents that	at	
		ons and a protein supplement for 3 of			have orders for therapeutic of		
		physician's orders for			have the potential to be affect		
		entions in a sample of			All tray cards were auditied a		
		•			compared to the physician of		
	12. (Residents #8	3, #24, and #31)			for accuracy. Any changes f were rectified.3. All nursing a		
					dietary staff will be inserviced		
	Findings include	:			following tray cards and mak		
					sure that the residents are se		
	1. Resident #31's	s record was reviewed on			their diets per physician orde	ers.	
	06/01/11 at 12 p.	m. The resident's			Dietary procedure has been		
	-	ed, but were not limited			changed to include a second		
	to, anemia and h				member to check the tray for accuracy before it is placed it		
	,	, , , , , , , , , , , , , , , , , , , ,			cart. Dietary Manager/Desig		
	The Dhygieign's I	Paganitulation Orders			will observe/audit 5 meal tray		
	-	Recapitulation Orders,			lines weekly X 30 days, mon		
	· ·	cated a diet order for			60 days and then 5 quarterly	to	
	large meat portio	ns.			ensure accuracy of diets ser		
					DON/Designee will observe		
	A care plan, date	d 05/17/11 indicated the			least 5 dining room meal ser		
	resident had low	protein levels. The			weekly X 30 days, 5 monthly days and then 5 quarterly for		
	approaches inclu	ded large meat portions.			accuracy of diets served. Ar		
	**				staff member found to be	.,	
	During an observ	vation on 06/01/11 at			noncompliant with service of		
	Daring an observ	whom on our of 11 th			physician ordered diet will be		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155667		A. BUI	LDING	00	COMPLETED	
		155667	B. WIN			06/07/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
			221 W DIVISION ST			
OAK GR	OVE CHRISTIAN R	ETIREMENT VILLAGE		DEMOT	TE, IN46310	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
		esident was served beef			subject to 1:1 reinstruction a further disciplinary action as	nu
	and noodles, there were 4 cubed pieces of beef on the resident's noodles on his plate.				appropriate.4. DON/Designe	ee
					will summarize results of aud	
		0.5/0.1/1.			and present data to the Qual	•
	· -	vation on 06/01/11 at 5:15			Assurance committee month identify trend/patterns warran	
	1 ~	t was served goulash.			further corrective action. Au	
	1 ~	the same serving size as			will continue past original tim	ne
	the others at the	table had been served.			frame until the QA Committe	e
					determines that a 95% compliance threshold is met.	5
		iew at the time of the			Date of compliance: July 7,	•
	1	Director of Nursing				
		ot look like the resident				
	received a large	meat portion.				
		s record was reviewed on				
	06/02/11 at 9 a.m					
	I -	ed, but were not limited				
	1 **	and congestive heart				
	failure.					
	1 -	Recapitulation Orders,				
		cated an order for large				
	meat servings wi	th lunch and dinner.				
		vation on 06/01/11 at 5:20				
	l * ·	t was served goulash,				
		me serving size as the				
	other residents ha	ad been served				
	· -	iew on 06/01/11 at 5:30				
		dicated the resident				
	received a regula	r portion of the goulash.				
	3. Resident #8's 1	record was reviewed on				
	6/1/11 at 1:00 p.1	m. Resident #8's				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667		ILDING	00	li i	LETED 2011
	NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE			221 W E	DDRESS, CITY, STATE, ZIP COI DIVISION ST TE, IN46310	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	diagnoses includ to, diabetes melli osteoporosis.	ed, but were not limited itus and severe					
	A physician's ord indicated "cotta meal."	der, dated 5/6/11, age cheese c (with) each					
	evening meal on	observed eating his 6/1/11 at 5:15 p.m. The received his cottage evening meal.					
	p.m., CNA #4 ind not sent the resid	dicated the kitchen had lent's cottage cheese. She is for reminding me."					
	3.1-21(b)						